PUBLIC CONSULTING GROUP

State of Wyoming
Department of Insurance

Health Benefits Exchange Planning

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1. Executive Summary

The Patient Protection and Affordable Care Act (ACA) was passed by Congress and signed by President Barack Obama on March 23, 2010. Amongst its many provisions, the law instructed states to create a Health Insurance Exchange (Exchange) through which citizens of the state can purchase health insurance. ACA compliant Exchanges must include a method to analyze an applicant's economic standing in order to determine if they are eligible for federal subsidizes to help defray the cost of insurance.

As part of the state of Wyoming's effort to decide how to best implement an Exchange for its citizens, the Public Consulting Group (PCG) was contracted to work with the state and provide background research on certain aspects of Exchange implementation. This following report represents the results of that engagement.

Wyoming asked PCG to analyze several Exchange organizational options for total cost. The first is creating a state based Exchange run by and for the state of Wyoming. Additionally, PCG was instructed to consider a regional exchange, in which multiple states would share a governance structure and exchange operations. The final model is establishing a state-based governance model, but sharing certain services with other states.

The following report includes a cost model for these Exchange scenarios, discusses potential funding sources for an Exchange, shares a work plan for Exchange implementation, and finally provides research on what actions other states have taken for Exchange implementation. Additionally, PCG engaged with a sub-contractor, Gorman Actuarial LLC, to research what affect Exchange implementation would have the insurance market in the state. This actuarial study is on-going, and the results from it will be provided once complete.

A summary of each section of the report is provided below. The full report begins following these summaries.

- *Financial Analysis*: This section of the report provides the methodology, assumptions, and estimated costs for the types of Exchanges under consideration by Wyoming.

- *Potential Funding Sources*: This section of the report discusses options for funding an Exchange, including noting what other states have done or are considering doing to finance their Exchange.

- *Potential Cost Allocation*: This section of the report discusses a CMS report on cost allocation among the Exchange, Medicaid, and Children's Health Insurance Program.

- *Work Plan for Exchange Implementation:* This section of the report provides a work plan for all of major tasks and milestones required for Exchange implementation. Dates are listed in the plan for guidance, but will likely be adjusted by state officials as final decisions about Exchange implementation are made.

- *State Action Review*: This section of the report provides information on the governance structure other states have chosen for their Exchange and also a peer state review with respect to the planning and implementation of Exchange.

2. Financial Analysis

2.1. Introduction

This section of the report presents the results of the review and assessment of the expected costs of operating the Wyoming Exchange. The report is separated into three main sections. First, the cost of Wyoming operating its own independent Exchange is estimated by identifying necessary Exchange functions and their costs. Next the costs of an assumed regional Exchange are explored. Then an estimate of possible cost reductions via sharing certain services with other states is provided. Finally, comparison data to the costs experienced or projected in other states is provided for context and comparison.

2.2. Necessary Exchange Functions and Budget Estimates

This section of the report provides a high-level description of the staffing, capabilities, and costs associated with operating a state-run Exchange in Wyoming. The description includes the resources needed to perform requirements laid out in guidance from the US Department of Health and Human Services, Center for Consumer Information and Insurance Oversight (CCIIO), and subsequent newly proposed rule making (NPRM) for the Establishment of Exchanges and Qualified Health Plans (proposed rules in 45 CFR Parts 155 and 156). PCG has included reasonable assumptions based on professional judgment, comparable data from Wyoming (where available), experience with other organizations that perform similar functions, and analysis of other publicly available data and reports.

Notwithstanding this effort, there are functions required of the Exchange for which there is no comparable experience on which to rely. In these cases, we have attempted to estimate the workload, qualifications of the staff, intensity of the work, and other factors that drive staffing and expenses.

The Exchange must carry out several functions required by the Affordable Care Act. Each of the minimum functions of an Exchange are listed below and set forth in Sections 1311(d)(4), 1341, 1343, and 1411-1413 of the ACA.

- Certification, recertification, and decertification of qualified health plans
- Call center

- Exchange website
- Premium tax credit and cost-sharing reduction calculator
- Quality rating system
- Navigator program
- Eligibility determinations for Exchange participation, advance payment of premium tax credits, cost-sharing reductions, and Medicaid
- Seamless eligibility and enrollment process with Medicaid and other State health subsidy programs
- Enrollment process
- Applications and notices
- Individual responsibility determinations
- Administration of premium tax credits and cost-sharing reductions
- Adjudication of appeals of eligibility determinations
- Notification and appeals of employer liability
- Information reporting to IRS and enrollees
- Outreach and education
- Risk adjustment and transitional reinsurance
- SHOP Exchange-specific functions

The estimates developed in this report address these CCIIO requirements and the business functions necessary to implement an Exchange. If the actual approach employed by the State varies from the assumptions made in this report, or if the State's final approach involves additional functions not contemplated here, then the estimates contained in this analysis (e.g. the staffing requirements and other expenses) could vary from actual results.

High level assumptions include:

- Determination of administrative requirements of the Exchange based on the CCIIO guidance regarding required functions outlined in the January 20, 2011 application and subsequent newly proposed rule making (NPRM) for the Establishment of Exchanges and Qualified Health Plans (proposed rules in 45 CFR Parts.

- Development of an assumed organizational structure and approach for performing the required functions.
- Identification of appropriate positions and job responsibilities necessary to carry out the work.
- Estimation of the number of full time equivalents (FTE) for each position based on ratios, volumes, and professional judgment.
- Determination of reasonable salaries for each position based on comparable positions in Wyoming and using the state's average pay rates as of April 30, 2011. This data was derived from the State of Wyoming's Department of Administration & Information Human Resources Division.
- Federal coverage of implementation costs prior to 2014.
- Addition of payroll taxes and benefits at a fringe benefit rate of 32%
- Addition of other direct costs derived using several different methodologies such as per member per month (PMPM) factors, estimated cost per FTE, or line item estimates.
- Eligibility and Enrollment cost estimate based on professional experience in other states.
- Call center estimates based on information from a call center in Maine and publicly available documents estimating the needs of a call center for North Carolina's future Exchange were analyzed. In addition, a call center calculation was applied.
- Utilization of existing similar entities including budget estimates from the Utah Health Exchange, the Massachusetts Connector FY 2010 budget, projections for North Carolina and Delaware, and professional judgment to estimate other Exchange business functions that include premium billing, marketing, navigators, website and it systems, and general administrative cost.

The Exchange population estimate utilized in the development of this report (30,500) was used to cost out a number of business functions. We would like to stress this is only an estimate and has not been vetted by full actuarial analysis. The estimate was created using publically available reports studying potential Exchange enrollment. The reports utilized were the Urban Institute's March 2011 Report "Who Will Be Uninsured After Health Insurance Reform?" and "Lower Taxes, Lower Premiums, Wyoming" a report from Families USA and the Lewin Group. The

Urban Institute study estimates that roughly 49,000 more citizens of Wyoming will have health insurance after the ACA is implemented, with 35,000 remaining uninsured in the state.

In order to extract the amount of people who receive coverage through Medicaid verses private insurance, a percentage over just over one third for Medicaid enrollment was used (37.7%). This number was extrapolated from the predicated amount of people remaining uninsured that are eligible for Medicaid in the report. After subtracting Medicaid enrollees, the Urban Institute can be seen to predict that the Exchange will have just over 30,500 enrollees. The figures from the Families USA report are comparable to the Urban Institute report. The report shows 59,700 citizens of the state being eligible for premium assistance via the ACA. Not all of these individuals will enroll, and a number of them are already insured. Families USA estimates 28,300 of those eligible for premium assistance are currently uninsured. This number is slightly below the total enrollment figure from the Urban Institute, but it is assumed that a certain churn will happen from those currently buying insurance on the open market who transition to buying insurance through the Exchange. These two figures reinforce one another, and provide a reasonable estimate of roughly 30,500 enrollees in the Wyoming Exchange.

It is important to stress that this estimate is only for scaling costs in this cost model, and will differ from the final estimate of Exchange enrollees in the actuarial report.

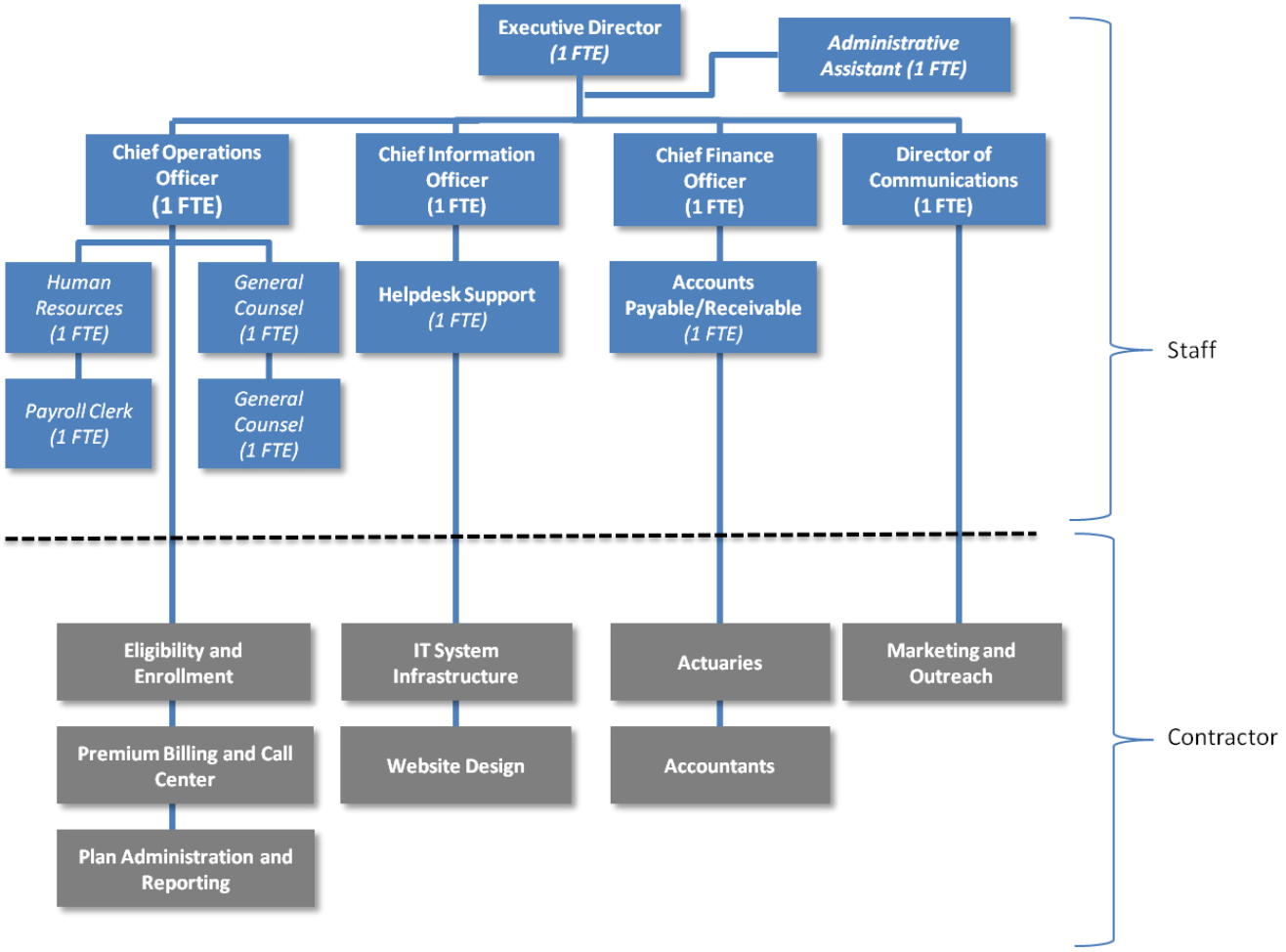
Full Time Employee Salary and Benefits

The Health Benefit Exchange will require a core group with executive level authority to operate the exchange. For this costing exercise as a single state entity, we have modeled the Exchange as a quasi public entity.

We envision that the HBE will be led by an executive leadership team comprised of top executives responsible for each of the major functional areas (operations, marketing, information systems, and finance). One Executive Director would act as the main authority figure, overseeing all decisions made by the agency. This position would oversee all Exchange operations, including:

- Operations – Directed by the COO, this unit will be responsible for the overall operation of the Exchange. HBE staff will be responsible for human resources, payroll, procurement, legal services, and contract management. For the purposes of this analysis, we have assumed Wyoming will leverage purchased services for eligibility and enrollment, premium billing, call center, and plan administration and reporting.
- Information Technology – Directed by the CIO, the Information Technology unit will manage the IT support structure of the exchange. This includes managing contracts with website design and hosting firms and managing the overall systems of the Exchange.
- Finance – Directed by the Controller, this unit will manage all accounting, accounts receivable/accounts payable, financial reporting, analysts, and specialty contractors. These individuals will include actuaries, CPAs, and other financial consultants as necessary.
- Communications – the Communications Office will manage the marketing contractor as well as the Navigator contracts for the exchange. All outreach functions will be managed by the Director of Communications for the Exchange.

The organizational chart below outlines the anticipated positions of the Exchange.



A review of existing documentation and literature was completed to develop the estimated staff of a Wyoming Exchange. This review included the existing Exchanges' operating budgets, the North Carolina Health Benefit Exchange Study published 7/18/11 by Milliman, and materials from various peer states. An organizational structure was designed that identified 12 positions. Salaries are benchmarked to comparable positions in Wyoming using the state's average pay rates as of April 30, 2011. This data was derived from the State of Wyoming's Department of Administration & Information Human Resources Division. For the fringe benefit calculation, PCG utilized a rate of 32%, which was provided by Wyoming contacts as a standard used by the state for budgeting exercises, and verified by contacts at Wyoming's Employee Group Insurance division.

The following chart shows the cost estimate of the salary and benefits of a Wyoming based exchange for these 12 FTEs.

Position	Responsibilities	WY Comparable Position	FTE's	Salary	Fringe (32%)	Total
Executive Director	Overall management and strategy of the organization	Executive Manager 8	1	$139,422	$44,615	$184,037
Controller	Financial duties, including accounting, purchasing, and actuarial activities	Accounting Manager III	1	$89,014	$28,484	$117,498
CIO	Information systems director	Computer Technology Operations Manager	1	$95,992	$30,717	$126,709
COO	Program development, business development, and public policy director	Executive Manager 6	1	$116,043	$37,134	$153,177
Administrative Assistant	Assist Executives	Office Support Specialist I	1	$31,179	$9,977	$41,156
Director of Communications	Marketing, outreach, and public relations director	Public Relations Supervisor	1	$59,030	$18,890	$77,920
Financial and Accounting Analyst	Provide data analyses, manages Exchange AP/AR and other financial tasks	Senior Budget Analyst	1	$72,071	$23,063	$95,134
Human Resources	Hiring, benefit design, and other HR functions	Human Resources Manager III	1	$82,638	$26,444	$109,082
Payroll, Benefit, and Benefit Compliance	Monitors benefit plans, completes federal reporting, processes payroll	SR HR Benefits Specialist	1	$45,262	$14,484	$59,746
General Counsel	Provides legal support services	Practicing Attorney 5	1	$105,914	$33,892	$139,806
Contracting / Procurement Agent	Manages RFP process and all other contracting	Purchasing Manager	1	$71,093	$22,750	$93,843
Information Technology Services	Support services and helpdesk functions	SR Computer Tech Bus Application Analyst	1	$67,205	$21,506	$88,711
TOTAL			**12**	**$974,863**	**$311,956**	**$1,286,819**

Enrollment and Eligibility System

Section 1311, 1411, and 1413 of the ACA identify many of the Exchange functions associated with enrollment and eligibility systems. This legislation and subsequent proposed regulations and guidance has articulated a broad vision of what an Exchange must do, how it must operate, and the desired outcomes from its establishment in each state. The ACA requires online, real time verification of application information to occur at the federal level through a series of interrelated

data matching protocols developed by the Secretary of HHS in conjunction with Homeland Security, Social Security Administration, and the Internal Revenue Service. At the most basic level, the Wyoming Exchange must verify that the applicant is qualified to purchase insurance through the Exchange. At this level, the cost is limited to the automated infrastructure. However for individuals applying for a premium subsidy, Medicaid, or CHIP the application process can be very complex.

All states have to decide on how eligibility for the Exchange, Medicaid, and CHIP will be streamlined and integrated as well as the degree to which existing IT systems will need to be integrated into the overall solution. The 4 primary options to address eligibility are as follows:

1. Modify existing systems to perform eligibility determinations on behalf of the Exchange
2. Implement a separate rules engine to perform eligibility determinations on behalf of the Exchange
3. Build a new eligibility system or replace existing eligibility system
4. Do nothing and rely on the Federal Exchange to perform determinations for the Exchange.

Each of the options above have positive and negative implications for the State in terms of the level of resources required, time to implement, likelihood of achieving compliance, and overall costs. In Wyoming's case, the State has already taken steps to address this key area of need for the Exchange through its planning for a new eligibility system for its Medicaid and CHIP programs, including the preparation of an Advance Planning Document (APD) to secure initial project funding from CMS. PCG assumes that such a solution, if developed, would be able to perform the eligibility determination needs for the Exchange as well, however further analysis will be needed to validate this assumption.

The table below summarizes the cost estimate ranges for each of the aforementioned options. These estimates are intended to be inclusive of all components including state personnel, contractor expenses, consulting services, software, and hardware for the entire lifecycle of the project. Ongoing Maintenance and Operations costs are estimated on an annual basis. These cost estimates have been developed from a range of sources from PCG's research and experience.

In particular these estimates rest on the following key assumptions and constraints:

- Any selected option will require state personnel time and modifications to existing systems at a minimum
- Estimated ranges are listed to account for variations in the solutions design and scope – ultimate cost will vary depending on final scope
- These estimates do not take into account the availability of federal matching funds in order to demonstrate the full costs of the system. In addition, the costs in the chart do not break out the cost to the Exchange itself verses the total costs of the system.

Description	One-Time Design, Development, and Implementation	Ongoing Maintenance and Operations
Option 1: Integrate changes into existing Eligibility Environment.	$4-6M	$600-900k
Option 2: Develop the Phased Integration with an Eligibility Engine solution to process eligibility determinations. (Use existing infrastructure.)	$10-20M	$1-3M
Option 3: Replace the entire eligibility system	$35-70M	$5-10M
Option 4: Do nothing and utilize the Federal Solution	$1.5M - $3M	$600-900k

As illustrated above, there are wide variations in the potential costs depending on the direction Wyoming takes to address the needs of the Exchange. Option 4 represents the least potentially expensive option because it does not require much systems development work, only integration of the Federal Solution into Wyoming's existing environment, but it is also the option with the most

uncertainty since the specifications of the Federal Exchange are not known at this time. Option 1, the next least expensive option, does not seem to be a feasible option given the State's determination that its existing systems do not meet the future needs of Medicaid or CHIP.

Options 2 and 3 represent the most expensive options in that they both involve development of new IT systems and platforms for eligibility. While the potential costs are much higher, both of these options are more likely to satisfy the federal guidance and standards for a modern, scalable, flexible and interoperable eligibility system. As a result, they also have the highest probability for the state to take full advantage of unique federal reimbursement opportunities for eligibility systems. As mentioned above, Wyoming has stated a preference to develop a new eligibility system for Medicaid and CHIP as a result of its findings that the current systems are unlikely to adequately support future business needs. A complete systems replacement, while necessary, is a significant and time-consuming endeavor and there is a high likelihood that it cannot be completed in the restrictive timeframes imposed by the ACA. Furthermore, PCG's analysis indicates a potentially much higher overall cost for a system replacement than the current estimates provided by the state.

As a result of these realities, a more phased approach to system replacement, utilizing a new eligibility rules engine for the immediate needs of the Exchange and meeting ACA mandates, and building a platform for additional enhancements for other aspects of eligibility, is perhaps a more attractive option. This approach is also one that many other states are currently contemplating who are in a similar position to Wyoming – relying on older, inflexible technology platforms and actively looking to transition to a new platform that is better suited for the current business needs.

Wyoming's current preference according the state's APD is pursue Option 3. Due to the concerns raised above this cost model blends the estimated costs of Options 2 and 3. Start-up costs are not included in the 2014 cost to the Exchange, since they are expected to be paid for via 100% Federal matching funds. In addition, for the Exchange cost model, PCG has broken out the costs the Exchange must pay from the cost of the complete system as a function of anticipated enrollment. This creates an ongoing maintenance cost estimate of **$1,051,748.**

Call Center

The ACA mandates that all Exchanges have an operational call center that can guide consumers through the process of purchasing care via an Exchange and also answer questions from individuals or businesses. Staff and costs requirements for the call center will be largely dependent on call volume, but there will also be a subset of fixed costs (e.g. management, rent, and equipment) that must be borne in times of very few calls just as in time of heavy call volume.

The cost of the call center will depend on staffing requirements, which in turn are very sensitive to call volume and call length, as well as the amount of time deemed acceptable for people to be on hold.

In order to estimate the potential cost of the Wyoming call center, information from a call center in Maine and publicly available documents estimating the needs of a call center for North Carolina's future Exchange were analyzed. This information provided benchmark data for use in understanding potential call volume of Wyoming's Exchange.

The following chart demonstrates the key variable factors for each call center:

Description	NC Estimate	Maine Data	Wyoming Estimate
Estimated Population	795,791	306,280	**30,500**
Estimated % Contact	25%	50%	**25%**
# of Contacts	198,948	153,140	**7,625**
# FTEs	30	30	**2**
Total Cost	$ 1,287,446	$ 1,227,189	**$108,409.58**

It is important to remember that the ultimate needs of the Wyoming call center will be highly sensitive to call volume, duration and service level. PCG developed this estimate based on the relationship of FTE's, # of contacts, and cost. Alternatively, we verified our FTE estimate by analyzing it against a call center calculation. An Exchange population of 30,500 and a contact percentage of 25% would mean Wyoming would receive roughly 30 calls per day, or 3-4 in an hour. Applying Little's Law, which is a restatement of the Erlang Formula, shows that mathematically there should be no more than one call occurring at any given time (assuming a

call time of eight minutes and a wrap up time of two minutes). Even when variability is taken into account, a total of two staff members should be able to handle total call volume each day. Salaries assume one Employee Services Specialist ($40,081.59) and one human resource manager ($68,327.99).

Given how few employees are required, it is assumed that they could be housed somewhere in existing state infrastructure and ancillary costs will be nominal.

Premium Billing and Website

Proposed rules from the Department of Health and Human Services released on July 11, 2011 clarified that SHOP Exchanges must bill and collect premiums from participating employers. This function was previously considered an optional Exchange function and, though the rules are not yet final, any cost model of an Exchange should include this functionality as precaution.

The premium billing "engine" is the IT component of premium billing, and the following cost estimate assume the state creates an automated solution to calculate premiums produce invoices and track payments. These estimates are derived from analyzing existing state systems that perform similar functions in other states, and professional judgment based on experience performing similar analysis in other states.

It is expected that the Federal government will provide 100% funding for the start-up costs of this function through the establishment grant process, thus only ongoing maintenance costs are included in the final cost estimate (starting in 2014) as they will be the only true costs the Exchange faces. However, for information purposes, total cost estimates are also provided below.

The Exchange's website is one of the most important and more expensive IT-related facets of an Exchange. The web portal will likely serve as the primary point of contact for consumers and employers to access information and conduct business with the Exchange as well as the central hub through which other IT systems and functions are accessed. Based on federal specifications and guidance, the portal must allow consumers the ability to determine their eligibility for health insurance assistance programs, compare options and enroll in the coverage of their choosing. The portal may also be designed for other online services for consumers, employers, and insurance

carriers and as such, it may require integration with a variety of other IT systems. These and other design elements of the portal will have an impact on its overall development costs. Also, its central position in the Exchange environment will more than likely lead to higher ongoing operations and maintenance costs relative to other Exchange IT solutions.

The following table summarizes the expected costs of these functions. For the purposes of the cost model, middle range estimates for the ongoing maintenance cost were chosen. This provides a cost of **$650,000** for the Web Portal and **$225,000** for the Premium Billing Engine.

Exchange IT Component	One-Time Design, Development and Implementation	Ongoing Operations and Maintenance
Web Portal	$1-3M	$300k-$1M
Premium Billing Engine	$1-2M	$150-300k

Other Contracted/Consulting Services

It is expected that the Exchange will also contract other significant business functions. The descriptions below identify likely areas where consulting services will be used, outline the operations, and provide the methodology for the cost estimate.

Marketing

The HBE will need to develop a comprehensive marketing plan that identifies outreach strategies to encourage individuals to apply for the individual and small group products. A direct market effort will educate the consumer on the new requirements, protections, and choices available. The execution strategy may include a media campaign and other traditional marketing activities as well as a community outreach campaign. The expense estimate is based on typical health plan advertising and promotion and assumes marketing is limited to a single state. Wyoming's Exchange will be free to market as much or as little as it chooses, and may rely on general public knowledge of the law and individual mandate more than its own marketing effort. However, for budgeting purposes, some marketing costs should be assumed.

Navigator Program

Per the ACA, the Exchange must have a Navigator program that assists with outreach and enrollment functions. The population targeted by the Navigators may include individuals without web-access, literacy, or insurance knowledge. The Navigator Program involves leveraging community resources to make information about the HBE available to potential consumers via existing channels such as community organizations, brokers, and state agencies. Navigators must be trained and registered and this service will be provided at the expense of the HBE. Navigators will conduct public education activities, distribute information about enrollment and premium credits, and provide enrollment assistance. An estimate of cost for Wyoming can be established by using industry estimates in other states, which have largely been based on the Massachusetts Connector's per-enrollee budget for "outreach" which is the only identified like data point found to date.

Actuarial Analysis

The HBE will require actuarial services as part of the plan qualification process and the risk adjustment process. The role of actuarial services would be significantly greater if the HBE is designed as an active or selective purchaser, negotiating premiums with insurers offering plans through the HBE. Furthermore, we anticipate that certain actuarial studies, such as adverse selection monitoring and comparisons of the market inside and outside the HBE, will be necessary.

Auditing

The Exchange will be required to submit Audited Financial Statements prepared according to standards applicable to the financial audits contained in Government Accounting Standards, issued by the Comptroller General of the United States. They require that a CPA plan and perform an audit to obtain reasonable assurances that statements are free of material misstatement. The audit will consider internal controls, accounting principles, disclosures, and overall financial presentation. On an annual basis the Exchange would need to contract for a Financial Statement and Independent Auditors Report with a third party CPA firm.

Legal and Other Professional Consulting

The HBE will likely face complex policy and regulatory problems that will require the assistance of a subject matter expert. This work could include government consulting services, regulatory advice and counsel, or public policy services.

General Administrative Costs

The Exchange will face a number of general administrative costs, including rent, supplies, utilities and other sundry items. A cost has been established for facility cost (plan operations, maintenance, security), depreciation, supplies, and other expenses. Assumptions for the costs are based on research into Wyoming costs and professional judgment.

The following chart shows the estimated costs.

General & Administrative	WY Cost	Assumptions
Facility Cost (Plan Operations, Maintenance, Security)	$178,400	$17/sq ft per yr NNN + .07/sq for insurance. Need 10,000 sq ft. - Based on industry standards for size and actual properties in Cheyenne for costs.
Depreciation	$22,262	12.5% of lease cost, based on professional judgment
Supplies	$8,000	Professional Judgment
Other Expense	$60,000	Professional Judgment
Total	**$268,662**	

Summary of Single State Wyoming Exchange Cost

Description	
Salary and Benefits	**WY CY 2014**
Executive Director	$184,037
Controller	$117,498
CIO	$126,709
COO	$153,177
Administrative Assistant	$41,156
Director of Communications	$77,920
Financial and Accounting Analyst	$95,134
Human Resources	$109,082
Payroll, Benefit, and Benefits	$59,746
General Counsel	$139,806
Contracting / Procurement Agent	$93,843
Information Technology Services	$88,711
Contract	**WY CY 2014**
Eligibility and Enrollment System	$1,051,748
Call Center	$108,410
Premium Billing Engine	$225,000
Marketing	$255,222
Navigator	$79,843
Actuarial	$92,300
Auditing	$14,531
Legal and Other Consulting Services	$163,028
IT and Website Design	$650,000
Other Indirect Expense	**WY CY 2014**
Facility Costs	$178,400
Depreciation	$22,262
Supplies	$8,000
Other Expense	$60,000
TOTAL	**$4,195,563**
Estimated Enrollment	30,500
PMPM	$11.46

2.3. Regional Exchange

A regional Exchange involves multiple states pooling resources and establishing one governance body for an Exchange for all of the participant states. Though the states could harmonize their health insurance laws and regulations and risk pool across state lines that is not a requirement for establishing a regional exchange but is likely necessary for a regional exchange to function. Regardless of the decision made on risk pooling, many other agreements would have to be reached among participant states before a regional Exchange could be established, including the relinquishing of a certain amount of each state's own power and authority. To date, no states have taken any official actions to enter into a regional Exchange with other states.

For a state with a small population such as Wyoming, a true regional Exchange could be an attractive option, despite the political and logistical difficulties. However, to date, no opportunity to share governance and enter into a regional Exchange has come to pass. However, for cost modeling purposes, PCG has assumed the following partners for a five state regional Exchange: Idaho, New Mexico, South Dakota, Utah, and Wyoming.

The methodology for costing a regional Exchange first focuses on creating an appropriate staffing model. Executive offices are expected to remain the same as a single state Exchange, but a greater number of lower level staff will be necessary. For ease of comparison purposes, Wyoming salaries were once again utilized.

Urban Institute enrollment estimations (using the same methodology described above for the Wyoming estimate) for each state in the partnership were combined in order to create a total enrollment figure for the regional Exchange. The total assumed enrollment figure is: **390,845**.

While the exact cost savings of a regional Exchange cannot be determined without having a thorough understanding of the resources and capabilities potentially available in partner states, the discussion below provides estimates of functional areas in which high, moderate, or low potential savings may be realized.

High Potential for Savings:

Executive Staffing

Running the executive office of an Exchange is believed to be highly scalable, with large duplication occurring with fifty states having their own governance models. Particularly with the low number of possible enrollees in Wyoming, it is likely that this functionality could be shared across states. However, with the small structure of the Wyoming specific Exchange governance body, it is likely that a regional exchange's governance entity will be larger in size, reducing the savings achieved from the Executive level.

Other Indirect Costs

The other indirect costs of the Exchange will include facility cost, depreciation, supplies, and other expense. An assumption was made that other indirect costs would be a function of full time equivalents (FTEs or # of staff).

Moderate Potential for Savings:

Call Center

Call centers are an area in which economies of scale can traditionally be achieved. However, given Wyoming's low contribution of enrollees to the regional exchange (estimated at under 10%), large savings are not expected from Wyoming's perspective.

Auditing and Actuarial:

Having a set financing and actuarial staff that can be cross trained and work to meet the requirements of each state will likely provide savings versus having independent functionality in each state. However, given state specific reporting requirements staff reductions and savings may be minimal.

Legal and Other Consulting Services

It is likely that legal and other consulting services staff could be shared with the same staff members working to meet the needs of each state. However, given that states have their own requirements, a significant reduction is not expected.

Information Technology and Website

Sharing a single IT system has high potential for savings in a regional exchange. However, if state health insurance and Medicaid regulations are not harmonized and the single system would still have to interface independently with each state's system, the total savings for a regional Exchange would decline.

Little to No Potential for Savings:

Enrollment and Eligibility System

While savings are possible for the general website and other IT functions, the need to process eligibility and enrollment will remain on a state by state basis, meaning there will be few economies of scale achieved via a regional Exchange.

Marketing

Traditional marketing efforts in the mass media could be leveraged to provide one message to the states in a regional exchange but a community outreach campaigns will be necessary in each state, and cost savings are not expected.

Navigators:

Each state will have to have its own navigators so significant savings are not expected.

Premium Billing Engine:

The billing engine is a fixed cost IT function, and a regional exchange is expected to face the same IT costs in this regard as single state exchanges.

The tables below highlight the estimated savings potential for the Salary and Benefits, Contract, and Other Indirect Cost.

	Legend			
Description	**A**	**B**	**C = A+(A*B)**	**D = C/5**
Salary and Benefits	**Single State Health Benefit Exchange**	**Additional FTE's Necessary to Operate a Regional HBE**	**Regional HBE Cost (Five States)**	**Regional Exchange Cost to Wyoming**
Executive Director	$184,037		$184,037	$36,807
Controller	$117,498		$117,498	$23,500
CIO	$126,709		$126,709	$25,342
COO	$153,177		$153,177	$30,635
Administrative Assistant	$41,156	4	$205,781	$41,156
Director of Communications	$77,920		$77,920	$15,584
Financial and Accounting Analyst	$95,134	4	$475,669	$95,134
Human Resources	$109,082	1	$218,164	$43,633
Payroll, Benefit, and Compliance	$59,746	1	$119,492	$23,898
General Counsel	$139,806		$139,806	$27,961
Contracting / Procurement Agent	$93,843	1	$187,686	$37,537
Information Technology Services	$88,711	4	$443,553	$88,711
Total	**$1,286,819**	**15**	**$2,449,492**	**$489,898**

	Legend		
	A	**B**	**C = A*B**
Contract Cost	**Single State Health Benefit Exchange**	**Regional HBE Discount**	**Regional Exchange Cost to Wyoming**
Eligibility and Enrollment System	$1,051,748		$1,051,748
Call Center	$108,410	87%	$93,828
Premium Billing Engine	$225,000		$225,000
Marketing	$255,222		$255,222
Navigator	$79,843		$79,843
Actuarial	$92,300	90%	$83,070
Auditing	$14,531	90%	$13,078
Legal and Other Prof. Consulting Services	$163,028	90%	$146,725
IT and Website Design	$650,000	85%	$552,500
Total	**$2,640,082**		**$2,501,015**

	Legend		
Description	**A**	**B**	**C = A*B**
Other Indirect Cost	**Single State Health Benefit Exchange**	**Regional HBE Discount**	**Regional Exchange Cost to Wyoming**
Facility Cost (Plan Oper., Maint., Security)	$178,400	45%	$80,280
Depreciation	$22,262	45%	$10,018
Supplies	$8,000	45%	$3,600
Other Expense	$60,000	45%	$27,000
Total	**$268,662**		**$120,898**

The following chart provides a summary of the estimated costs for a single state Wyoming Exchange and the cost to Wyoming of the assumed regional exchange. These costs are estimates only and real costs will vary as a function of participating states and actual enrollment in the Exchange. In addition, political negotiations on cost sharing would likely drive the final costs to each state of a regional Exchange. Here, it has been assumed each state pays an equal share.

Summary of Single State vs. Regional Cost Estimate		
	Single State Health Benefit Exchange	**Regional Exchange Cost to Wyoming**
Salary and Benefits	$1,286,819	$489,898
Contract Cost	$2,640,082	$2,501,015
Other Indirect Cost	$268,662	$120,898
Total	**$4,195,563**	**$3,111,811**

2.4. Wyoming Governed Exchange with Shared Services

In this model, Wyoming would establish its own state based Exchange governed entirely in Wyoming. This means the state would have the same costs for salaries as well as other indirect costs (e.g. rent) as in a Wyoming exclusive Exchange. However, other services could be shared with other states. It is possible that Wyoming could contract services from other states or share vendor services with other states, finding reductions in total cost via economies of scale.

This organizational method is expected to be easier to achieve than full regional exchange with shared governance. Despite relative ease in establishment, significant work remains to be done before a share services model can be a reality.

The following analysis is intended to provide a high level estimate for possible savings within a shared services model. Final costs will depend on the actual services shared and sharing partners.

In order to create a cost estimate, PCG analyzed each necessary area of an Exchange for possible economies of scale and savings. Areas of potential savings are:

- Call Center
- Actuarial
- Auditing
- Legal and Other Consulting Services

	Legend		
	A	**B**	**C = A*B**
Contract Cost	**Single State Health Benefit Exchange**	**Shared Services HBE Discount**	**Shared Services Exchange Cost to Wyoming**
Eligibility and Enrollment System	$1,051,748		$1,051,748
Call Center	$108,410	87%	$93,828
Premium Billing Engine	$225,000		$225,000
Marketing	$255,222		$255,222
Navigator	$79,843		$79,843
Actuarial	$92,300	90%	$83,070
Auditing	$14,531	90%	$13,078
Legal and Other Prof. Consulting Services	$163,028	90%	$146,725
IT and Website Design	$650,000	85%	$552,500
Total	**$2,640,082**		**$2,501,015**

2.5. Summary of Cost Estimates

Salary and Benefits	Single State Health Benefit Exchange	Regional Health Benefit Exchange	Shared Services Health Benefit Exchange
Executive Director	$184,037	$36,807	$184,037
Controller	$117,498	$23,500	$117,498
CIO	$126,709	$25,342	$126,709
COO	$153,177	$30,635	$153,177
Administrative Assistant	$41,156	$41,156	$41,156
Director of Communications	$77,920	$15,584	$77,920
Financial and Accounting Analyst	$95,134	$95,134	$95,134
Human Resources	$109,082	$43,633	$109,082
Payroll, Benefit, and Benefit Compliance	$59,746	$23,898	$59,746
General Counsel	$139,806	$27,961	$139,806
Contracting / Procurement Agent	$93,843	$37,537	$93,843
Information Technology Services	$88,711	$88,711	$88,711
Subtotal - Salaries and Benefits	**$1,286,819**	**$489,898**	**$1,286,819**
Contract			
Eligibility and Enrollment System	$1,051,748	$1,051,748	$1,051,748
Call Center	$108,410	$93,828	$93,828
Premium Billing Engine	$225,000	$225,000	$225,000
Marketing	$255,222	$255,222	$255,222
Navigator	$79,843	$79,843	$79,843
Actuarial	$92,300	$83,070	$83,070
Auditing	$14,531	$13,078	$13,078
Legal and Other Prof. Consulting Services	$163,028	$146,725	$146,725
IT and Website Design	$650,000	$552,500	$552,500
Subtotal - Contract Cost	**$2,640,082**	**$2,501,015**	**$2,501,015**
Other Direct Expense			
Facility Cost (Plan Oper., Maint., Security)	$178,400	$80,280	$178,400
Depreciation	$22,262	$10,018	$22,262
Supplies	$8,000	$3,600	$8,000
Other Expense	$60,000	$27,000	$60,000
Subtotal - Other Direct Expense	**$268,662**	**$120,898**	**$268,662**
TOTAL	**$ 4,195,564**	**$ 3,111,811**	**$ 4,056,496**
Estimated Enrollment	**30,500**	**30,500**	**30,500**
PMPM	**$11.46**	**$8.50**	**$11.08**

2.6. Cost Estimates from Other States

This section of the report provides research on the costs of other states' Exchanges. Only two states (Massachusetts and Utah) currently have operating Exchanges so the summary includes what has been estimated in a few other states in addition.

Delaware

PCG serves as the consultant to Delaware for the state's Health Benefit Exchange planning. Part of PCG's efforts on the state's behalf includes creating an Exchange enrollment estimate as well as a cost model. For comparison purposes for Wyoming, the estimates PCG created for Delaware are included in the comparison chart.

Illinois

Health Management Associates and Wakely Consulting recently conducted an Exchange analysis report for the state of Illinois. This included cost projections and enrollment estimations for the Exchange. The report is largely based on assumptions for Illinois as a function of the Massachusetts Connector. PCG analyzed this report for total costs and applied its costing methodology to the report's data in order to create a comparison for Wyoming.

Massachusetts

Massachusetts currently runs the most ACA-like Exchange in the nation. Though not fully compliant in current form, the Massachusetts Connector does include functionality such as premium subsidies that must be part of any ACA compliant exchange. As such, it is beneficial to consider its costs. In order to summarize the cost of the Connector, PCG reviewed the FY 2010 Audited Financial Statements as well as the FY 2008 Operating Budget.

North Carolina

Milliman recently conducted an Exchange analysis for the State of North Carolina. This included a projection on the cost to run an Exchange for the first three years of operation (beginning January 1, 2014). The report based assumptions for the activities, functions and expenses of the

Exchange upon the activities, functions, and expenses of the Massachusetts Connector. The analysis included suggested staffing needs and capabilities, as well as proposed methodologies (e.g. assessments, user fees, etc.) for generating funds sufficient to support operation of the Exchange and its related services, as provided by the Act (e.g. Navigator grants, IT operations, outreach, etc.) along with the costs associated with each method.

Utah

The Utah Exchange does not release public financial statements and total costs of the Exchange are unclear. However by speaking with a Utah official, a general estimate for Exchange costs was created for information purposes.

Summary of Other State Health Benefit Exchange Administrative Cost

Category	Delaware	Massachusetts	North Carolina	Illinois	Utah	Wyoming
Salary Staff	$1,059,828	$5,861,126	$6,127,839	$7,314,712	$500,000	$1,286,819
Eligibility and Enrollment	$2,000,000	$5,506,397	$314,684	$7,215,427	N/A	$1,051,748
Call Center	$251,464		$1,480,391	$9,363,531	N/A	$108,410
Premium Billing Engine	$2,315,859	$9,781,251	$3,000,000	$4,048,350	N/A	$225,000
Marketing	$555,906	$1,598,273	$4,759,068	$2,313,343	N/A	$255,222
Navigator	$173,908	$500,000	$1,983,950	$1,900,246	N/A	$79,843
Actuarial	$201,042	$578,012	$103,363	N/A	N/A	$92,300
Auditing	$31,651	$91,000	$384,741	N/A	N/A	$14,531
Legal and Other Professional Consulting Services	$347,655	$1,020,930	$3,000,000	$2,148,104	N/A	$163,028
IT and Website Design	$566,395	$1,628,428	$1,000,000	$798,654	$302,400	$650,000
General Administrative Costs	$259,982	$747,469	$512,250	$1,108,814	N/A	$268,662
Other	$0	$139,104	$1,093,464	$3,111,998	N/A	$0
Total	**$7,763,690**	**$27,451,990**	**$23,759,750**	**$39,323,179**	**$802,400**	**$4,195,563**
Enrollment	**66,443**	**190,000**	**714,222**	**486,000**	**4,200**	**30,500**
PMPM	**$9.74**	**$12.04**	**$2.77**	**$6.74**	**$15.92**	**$11.46**

North Carolina had exceptionally low Administrative PMPM estimates due to economies of scale, missed cost (e.g. Eligibility and Enrollment cost in North Carolina was essentially ignored), and larger population bases. Utah's estimate is a best approximation based on incomplete information.

3. Potential Funding Sources

A number of options exist to generate the revenue that will be necessary to run a self-sustaining Exchange after 2014. The below list includes the most common approaches thus far, as well as some ideas that have not yet been tried.

- Retention of a portion of premiums from health plans offering coverage through the Exchange (Massachusetts)
- Assessing a surcharge on top of the premiums paid by consumers (Utah)
- Assessing state fees on businesses that do not offer insurance to employees
- Establishing a premium tax on all health carriers, regardless of Exchange participation (California)
- Creating a hospital surcharge on services
- Allowing insurers to advertise other product offerings (e.g. supplemental lines, life insurance, long-term care) on the Exchange website
- Selling general advertising on Exchange website

Wyoming would have the option of using one of these approaches, a combination of approaches, or other ideas the State may prefer. Though some of the options may appear to avoid costs to citizens of the state (e.g. premium retention) it is likely that most, if not all, of those costs would ultimately be passed on to the consumer. Advertising on the Exchange website may raise possible ethical concerns about implied Exchange endorsement of the products, but is also a way to fund at least a portion of Exchange operations with a less direct impact on consumers.

Steering Committee members were interested in possibly using premium subsidy money from the federal government to defray the cost of Exchange operations. This option is not considered on the list because premium subsidies will take the form of tax credits for those who receive them. For individuals with an income so low that they cannot afford to pay premiums and then receive a tax credit, a payment will be made on their behalf to their insurer. While the Exchange is responsible for determining the advance payment and/or cost sharing reduction, it will not have access to any funds that could be appropriated to fund running the Exchange itself.

4. Potential Cost Allocation

In May of 2011, the Centers for Medicare and Medicaid Services (CMS) in partnership with the US Department of Health and Human Services (HHS) released a report entitled Guidance for Exchange and Medicaid Information Technology Systems. The report includes a description of nine functional categories, summarized below, that must be cost allocated among the Exchange, Medicaid, and Children's Health Insurance Program (CHIP).

1) Health Care Coverage Portal: the online service that is used to support and populate a single, streamlined application

2) Business Rules Management and Operations: the system that contains and applies eligibility rules for individuals covered under MAGI

3) Interfaces to the federal data services hub

4) Interfaces to other verification sources

5) Account creation and case notes: the establishment and maintenance of electronic case files

6) Notices: communications regarding eligibility determinations and notices of referral to Medicaid for individuals who may be eligible on a basis other than MAGI

7) Customer service technology support: assistance to applicants in completing online or print applications, as well as supporting call centers and related applications

8) Interfaces to Navigators, community assistance programs, and other outreach organizations

9) All necessary enabling services to support these functions, such as identity management, security, and privacy controls

The above list represents the functional categories that CMS and HHS expect will be cost allocated by each state's Exchange. However, they are strongly encouraging states to use this transition period to make efficient investments that will improve overall program performance

and customer service. As such, additional services, such as those listed below may be cost allocated under the appropriate circumstances.

- All of the above listed functions for individuals who are eligible based on non-MAGI criteria
- Member education, selection, and enrollment in plans
- Communications and contracting with plans
- Risk adjustment

Any capabilities that have already been developed and paid for by Medicaid, CHIP, or another federally subsidized program should not be retroactively cost allocated. However, if development is still in progress, the state should recalculate and adjust cost allocation on a prospective basis.

5. Work Plan for Exchange Implementation

The following work plan includes all major tasks and milestones required for Exchange implementation. The details and timing of specific tasks were informed by federal guidance, including the January 2011 Cooperative Agreement to Support Exchange Establishment and the recent newly proposed rule making (NPRM) issuances. The start dates and durations of many of these tasks will depend largely on Wyoming's current level of preparedness and protocols for procurement and regulatory approval. Therefore, key milestone dates are denoted in red as firm guideposts for timing purposes.

While the major tasks of the work plan will remain the same whether Wyoming chooses to partner with another state or establish a single state Exchange, procurement needs and task durations may be altered or shortened depending on efficiencies gained through such a partnership. However, in order to ensure that the Exchange created through a multi-state partnership appropriately serves the needs of Wyoming's residents, the State should provide oversight for, if not directly participate in, all Exchange implementation activities under this model.

Functional Area	Task	Start Date	End Date
Governance	Develop governance model and draft legislation	10/1/2011	12/30/2011
	Submit legislation and appoint a governing board for the Exchange	2/13/2012	5/1/2012
Exchange IT Systems	Complete IT gap analysis	Completed	
	Complete review of product feasibility, viability, and alignment with Exchange functions	10/15/2011	1/30/2012
	Complete preliminary business requirements and develop IT architecture and integration framework	10/15/2011	1/30/2012
	Complete Systems Development Life Cycle	10/15/2011	1/30/2012

	(SDLC) implementation plan		
	Complete security risk assessment and release plan	10/15/2011	1/30/2012
	Complete preliminary design and system requirements documentation	10/15/2011	1/30/2012
	Finalize IT and integration architecture. Complete final business requirements and interim design and system requirements documentation	12/1/2011	2/28/2012
	Complete final requirements documentation, including system design, interface control, data management, and database design	1/1/2012	3/30/2012
	Complete preliminary and interim development of baseline system and review and ensure compliance with business and design requirements	1/1/2012	6/30/2012
	Complete final development of baseline system including software, hardware, interfaces, code reviews, and unit-level testing	7/1/2012	9/30/2012
	Complete testing of all system components including data and interfaces, performance, security, and infrastructure	10/1/2012	12/30/2012
	Complete final user testing including testing of all interfaces	2/1/2013	4/30/2013
	Complete pre-operational readiness review to validate all system components, end to end testing, and security control	5/1/2013	6/30/2013
	Prepare and deploy all system components to production environment	7/1/2013	9/30/2013
Program Integration	Perform detailed business process documentation for current State business	10/15/2011	12/30/2011

	processes and changes required to support Exchange		
	Execute agreement with State Department of Insurance to determine roles/responsibilities of Exchange and DOI	5/1/2012	6/30/2012
	Execute agreement with State Medicaid Agency and any other public program to determine responsibilities for eligibility determination, verification, and enrollment; strategies for mitigating program integration issues; cost allocation strategies	5/1/2012	6/30/2012
	Coordinate launch of open enrollment period with Medicaid and other public programs	10/1/2013	10/1/2013
Financial Management	Establish financial management structure and commit to hiring accountants to support financial management activities	12/1/2011	1/30/2012
	Determine if legislation is necessary to assess fees in support of Exchange	1/1/2012	2/1/2012
	Develop and release RFP for financial management services, select vendor	1/30/2012	4/30/2012
	Develop plan to ensure sufficient resources to support ongoing operations	4/30/2012	7/20/2012
	Assess adequacy of accounting and financial reporting systems	7/1/2012	8/30/2012
	Conduct third party review of all systems of internal control	10/1/2012	12/30/2012
	Demonstrate ability to publish all expenses, receivables, and expenditures consistent with Federal requirements	12/1/2013	12/30/2013
Program Integrity	Establish procedures for external, independent financial audit by a qualified	7/1/2012	8/30/2012

	auditor		
	Establish fraud detection and reporting procedures according to HHS guidelines	1/1/2013	6/30/2013
Eligibility Appeals and Complaints	Establish protocols for appeals including review of standards and timelines	1/1/2012	3/30/2012
	Draft scope of work for building capacity to handle appeals functions	4/1/2012	6/30/2012
	Establish process for reviewing consumer complaint information when certifying qualified health plans	7/1/2012	9/30/2012
	Establish resources for handling appeals of eligibility determinations including training procedures	10/1/2012	12/30/2012
	Begin receiving and adjudicating appeals requests	10/1/2013	10/1/2013
Certification of QHPs	Develop standards for certification	11/1/2011	1/30/2012
	Develop certification policy including timeline for application submission, evaluation, and selection	11/1/2011	1/30/2012
	Develop staffing and IT strategy to receive, process, and approve applications	1/30/2012	3/30/2012
	Launch plan management and bid evaluation system to allow upload of qualified health plan bids and other information	11/1/2012	11/1/2012
	Solicit premium quotes from health plan issuers	11/1/2012	1/30/2013
	Complete certification of qualified health plans and execute contracts	1/30/2013	3/30/2013
	Issue announcement on the selection of	4/1/2013	4/1/2013

	qualified health plans		
	Conduct plan readiness reviews (test enrollment interfaces with plans, review member materials, test financial reconciliation)	4/1/2013	7/30/2013
Call Center	Issue call center RFP and select vendor	7/1/2012	12/30/2012
	Develop call center customer service representative protocols and scripts to respond to FAQs	1/1/2013	3/30/2013
	Develop protocols for accommodating disabled individuals, as well as foreign language and translation services	1/1/2013	3/30/2013
	Train call center representatives on eligibility verification and enrollment	4/1/2013	7/30/2013
	Launch call center functionality and publicize toll free number	7/30/2013	7/30/2013
Exchange Website	Develop requirements for program operations, including those related to comparison of qualified health plans, online selection and application, tax credit and cost sharing calculators, requests for assistance, and links to other public subsidy programs	12/15/2011	1/30/2012
	Web portal RFP procurement process	1/15/2012	3/28/2012
	Begin systems development	4/1/2012	8/30/2012
	Submit content for information website to HHS for comment	9/30/2012	9/30/2012
	Complete systems development and final user testing	10/1/2012	1/30/2013
	Launch information website	3/30/2013	3/30/2013

	Collect and verify plan data for comparison tool	4/1/2013	6/30/2013
	Test comparison tool with consumers and stakeholders	4/1/2013	6/30/2013
	Launch comparison tool with pricing information but without online enrollment function	7/30/2013	7/30/2013
	Launch full comparison tool and enrollment functionality	10/1/2013	10/1/2013
Quality Rating System	Draft contract for qualified health plans based on HHS rating system	11/1/2011	2/30/2012
	Complete system development of quality rating functionality	4/1/2012	9/30/2012
	Complete testing and validation of quality rating functionality	10/1/2012	12/30/2012
	Post quality rating system information on Exchange website	4/1/2013	6/30/2013
Navigator Program	Develop high level milestones and timeframe for the program	11/1/2011	12/15/2011
	Determine target organizations in the State who would qualify to function as Navigators	1/1/2012	3/30/2012
	Develop and release Navigator RFP	4/1/2012	10/30/2012
	Award contract for Navigators	12/1/2012	12/1/2012
	Train Navigators on Exchange functions and enrollment processes	12/2/2012	6/30/2013
Eligibility Determinations	Finalize requirements for integrating with OASHSPs to support enrollment transactions, coordinating applications and notices, managing transactions, and communicating	10/15/2011	12/30/2011

	enrollment status of individuals		
	Systems development and prep for final user testing, including testing of any systems within OASHSPs	1/1/2012	1/30/2013
	Final user testing for all interfaces	2/1/2013	4/30/2013
	Begin conducting eligibility determinations for OASHSPs	10/1/2013	10/1/2013
Enrollment Process	Develop requirements for systems and program operations, including providing plan information, submitting enrollment transactions to QHP issuers, receiving acknowledgement of enrollment transactions, and submitting data to HHS	10/15/2011	12/30/2011
	Systems development and prep for final user testing	1/1/2012	1/30/2013
	Final user testing for all interfaces	2/1/2013	4/30/2013
	Begin enrollment in qualified health plans	10/1/2013	10/1/2013
Applications and Notices	Develop requirements for Exchange created applications and notices	1/1/2012	6/30/2012
	Finalize all applications and notices including review, testing, and translation of content	10/1/2012	3/30/2013
Exemptions	Develop requirements for accepting, reviewing, and adjudicating requests, and relaying information to HHS	11/15/2011	2/30/2012
	System development and prep for final user testing	1/1/2012	1/30/2013
	Final user testing for all interfaces	2/1/2013	4/30/2013

	Begin processing exemptions from individual responsibility and payment	9/1/2013	9/1/2013
Premium Tax Credit and Cost Sharing Reduction Administration	Develop requirements for systems and program operations, including providing information to QHP issuers and HHS to start, stop, or change the level of premium tax credits and cost sharing reductions	10/15/2011	12/30/2011
	Systems development and prep for final user testing	1/1/2012	1/30/2013
	Final user testing for all interfaces	2/1/2013	4/30/2013
	Begin submitting tax credit and cost sharing reduction information to QHP issuers and HHS	10/1/2013	10/1/2013
Premium Aggregation for SHOP Exchange	Develop requirements for systems and program operations to collect and distribute premiums from small business owners to qualified health plans	11/1/2011	1/30/2012
	Systems development and prep for final user testing	1/1/2012	1/30/2013
	Final user testing for all interfaces	2/1/2013	4/30/2013
	Begin submitting tax credit and cost sharing reduction information to QHP issuers and HHS	10/1/2013	10/1/2013
Notification and appeals of employer liability for employer responsibility payment	Develop requirements for systems and program operations, including coordination of employer appeals with individual eligibility appeals, and submission of data to HHS	10/15/2011	12/30/2011
	Systems development and prep for final user testing	1/1/2012	1/30/2013
	Final user testing for all interfaces	2/1/2013	4/30/2013
	Begin notifying employers in coordination with eligibility determinations	10/1/2013	10/1/2013

Information reporting to IRS and enrollee	Develop requirements for systems and program operations, including capturing data in enrollment process, submitting data to HHS, generating information reports for enrollee	10/15/2011	12/30/2011
	Systems development and prepare for final user testing	1/1/2012	1/30/2013
	Complete final user testing for all interfaces	2/1/2013	4/30/2013
	Confirm that systems are prepared to generate information reports to enrollees	5/1/2013	7/30/2013
Outreach and Education	Develop high level outreach and education plan including milestones and contact strategy	10/15/2011	11/30/2011
	Develop and issue RFP for market research firm	1/1/2012	3/30/2012
	Develop performance metrics and evaluation plan	1/1/2012	3/31/2012
	Perform environmental scan to assess outreach and education needs and determine geographic/demographic areas for outreach efforts	4/1/2012	6/15/2012
	Design media strategy and other information dissemination tools	6/1/2012	7/1/2012
	Submit outreach and education plan to HHS, including performance and evaluation	7/1/2012	7/1/2012
	Test materials with key stakeholders and refine as necessary	7/31/2012	12/28/2012
	Launch outreach and education plan	1/1/2013	1/1/2013
Transitional Reinsurance	Develop and release RFP for reinsurance program, select one or more vendors for contract	7/1/2012	3/28/2013

6. State Action Review

The following pages discuss what actions other states have taken thus far in Exchange planning, including a summary chart of actions and more detail on states identified by Wyoming officials.

6.1. Governance Structure

As defined by the ACA, states have a degree of flexibility in determining the governance structure for the Exchange. Of the 13 states that have made formal governance decisions regarding the establishment of an Exchange, three are planning an Exchange that exists within a current government agency:

- Utah – Office of Consumer Health Services
- Vermont – Vermont Health Access Commissioner's Office and advisory committee
- West Virginia – Insurance Commissioner's Office

Additionally, seven states have established quasi governmental agencies (California, Colorado, Connecticut, Massachusetts, Maryland, Washington, and Oregon), one has decided to house the Exchange as a separate, non-profit entity (Hawaii), and two states (Nevada and Rhode Island) have opted to establish the Exchange as an independent state agency. Hawaii has the largest Exchange board with 15 members. California and Vermont have the smallest, with 5 members each.

Below are examples of peer state Exchange board compositions that have been finalized by other states. While there are overarching themes among all boards analyzed, each state has taken a slightly different tack that may be useful for Wyoming to consider in further defining its Exchange board.

Exchanges within State Agencies

Utah

Utah's Exchange Board consists of up to nine members. Of those members between six and eight may be appointed by the Governor with the Insurance Commissioner serving as an ex officio

board member. Three to five board members must have actuarial experience. In addition, board members must include individuals representing the interests of the following groups:

- Insurance Carriers
- Employers and employees
- Office of Consumer Health Services
- Public Employees Health Benefit Program

West Virginia

West Virginia's Exchange Board consists of ten individuals. Two appointees to the board are selected by advisory groups, one consisting of health insurance carriers and the other provider associations, including the West Virginia Hospital Association and Pharmacists Association. The board composition is as follows:

- Insurance Commissioner, serving ex officio as the chair
- Director of the West Virginia Medicaid Office, or designee
- Director of the West Virginia Children's Health Insurance Program, or designee
- Chair of the West Virginia Health Care Authority, or designee
- Four members appointed by the Governor who represent the interests of individual consumers, small employers, organized labor, and insurance producers or navigators
- One member representing the interests of payers, selected by an advisory group of ten carriers having the highest health insurance premium volume in the state. Beginning in 2014, the advisory group will be limited to carriers that offer qualified health plans through the Exchange.
- One member representing the interest of providers, selected by an advisory group consisting of eight provider associations.

Exchanges as Quasi Governmental Agencies

Note on Quasi Governmental Agencies: While the definition of a quasi-governmental agency varies widely, partly based on individual state laws with respect to such agencies, this structure can generally be defined as an agency that is created by the State, operated under State oversight, but which is not under the direct control of the Governor's office and may not be subject to certain state laws.

Specifically, some states have chosen to establish a quasi governmental agency in order to leverage flexibility with respect to hiring and procurement practices. California included in their legislation a comprehensive process for hiring and determining appropriate but competitive Exchange employee salaries. Other states have cited time consuming state procurement processes as a reason for quasi-governmental agency establishment. While ensuring the integrity of procured services and health plans will be critical to the Exchange, turnaround time on these processes is also crucial. By creating a procurement system that is separate from the State system, the Exchange may be able to produce greater efficiencies and expedite contracting.

However, as a quasi governmental agency and depending again on state laws, the Exchange may need to invest more upfront in the establishment of its infrastructure and communication with state agencies. Additionally, although Exchange employees may benefit from more competitive salaries, they may not be able to participate in the state employees benefit plan.

Colorado

Colorado's Exchange Board consists of 12 members. While a number of states have strictly prohibited all voting members from having a direct affiliation with insurers, agents, or brokers, Colorado has stipulated that the *majority* of voting members cannot be affiliated with the insurance industry, leaving the option open to allow insurance industry stakeholders to vote on Exchange policy. The board is comprised as follows:

- Executive Director of Department of Health Care Policy and Financing
- Commissioner of Insurance
- Director of the Office of Economic Development and International Trade
- Five members appointed by the Governor

- One member appointed by the President of the Senate
- One member appointed by the Majority and Minority Leaders of the Senate
- One member appointed by the Speaker of the House
- One member appointed by the Minority Leader of the House

Washington

Washington's Exchange was established as a "public-private partnership that is separate from the State." The Board consists of 11 members, with the Commissioner of Insurance and Administrator of Health Care Authority acting as ex-officio members. The remaining nine members are appointed by the Governor, four of whom will be drawn from a pool of nominees submitted by the House and Senate. Those nominees must include the following:

- An employee benefit specialist,
- A health economist or actuary,
- A consumer advocate, and
- A small business owner.

Additional members are chosen based on their expertise in the following areas:

- Individual health care coverage,
- Small employer health care coverage,
- Health benefits plan administration,
- Health care finance and economics,
- Actuarial science, or
- Administering a public or private health care delivery system.

Exchanges as Independent State Agencies

Nevada

Nevada's Exchange Board has a total of ten members. Within the conflict of interest provisions of their legislation, Nevada specifies that voting members may not be legislators, elected officials in state government, state or municipality employees, or affiliated with a health insurer. Board membership includes:

- Director of Department of Health and Human Services
- Director of Department of Business and Industry
- Director of Department of Administration
- Five voting members appointed by the Governor
- One voting member appointed by the Senate Majority Leader
- One voting member appointed by the Speaker of Assembly

The chart beginning on the following page summarizes the board member composition and unique governance provisions for each state that has enacted legislation or signed an Executive Order to establish an Exchange.

STATE	Governance Structure	Name of Board	No. of Members	Board Member Requirements	Term limits and other restrictions	Additional Boards or Committees Established
California	Quasi Governmental	*Exchange Board*	5	• Secretary of Health and Human Services • 2 appointed by Governor • 1 appointed by Senate Rules Committee • 1 appointed by Assembly Speaker	• No affiliation with carrier or insurer, agent or broker, provider, facility or clinic, or trade association for these entities • Cannot be a provider paid for services rendered or have ownership interest in health care practice	
Colorado	Quasi Governmental	*Board of Directors*	12	• Executive Director of Department of Health Care Policy and Financing • Commissioner of Insurance • Director of the Office of Economic Development and International Trade • 5 appointed by the Governor • 1 appointed by the President of the Senate • 1 appointed by the Majority and Minority Leaders of the Senate • 1 appointed by the Speaker of the House • 1 appointed by the Minority Leader of the House	• Majority cannot be affiliated with insurance industry • Cannot be a state employee • Cannot participate in Exchange activities in which they have a financial interest	

Connecticut	Quasi Governmental	*Advisory Board*	14	• Insurance Commissioner, or designee • The Public Health Commissioner, or designee • Healthcare Advocate • The Social Services Commissioner • Special Advisor to the Governor on Healthcare Reform • Office of Policy and Management (OPM) Secretary, or designee • 8 voting board members: ○ Individual Health Insurance Expert ○ Small Employer Health Insurance Expert ○ Healthcare Finance Expert ○ Healthcare Benefits Plan Administration Expert ○ Healthcare Delivery Systems Expert ○ Healthcare Economics Expert ○ Self Employed Individuals' Healthcare Access Issues Expert ○ Barriers to Individual Healthcare Coverage Expert	• Members serve 4 year terms after initial term length • Initial term lengths are as follows: ○ Individual Health Insurance Expert: 3 years ○ Small Employer Health Insurance Expert: 2 years ○ Healthcare Finance Expert: 4 years ○ Healthcare Benefits Plan Administration Expert: 4 years ○ Healthcare Delivery Systems Expert: 2 years ○ Healthcare Economics Expert:1 year ○ Self Employed Individuals' Healthcare Access Issues Expert: 3 years ○ Barriers to Individual Healthcare Coverage Expert:2 years	The board may create such advisory committees as it deems necessary to provide input on issues that may include, but not be limited to, customer service needs and insurance agent and broker concerns
Hawaii	Private Non-Profit	*Board of Directors*	15	• Director of Health • Director of Human Services • Director of Labor and Industrial Relations • Director of Commerce and Consumer Affairs • 11 appointed by Governor with the	• Members must recuse themselves when they have a financial interest in the outcome	

				following affiliations: ○ 3 insurance plans ○ 1 provider group ○ 1 hospital trade association ○ 1 health care consumer ○ 1 labor management ○ 1 native Hawaiian health care organization ○ 1 federally qualified health center ○ 1 business ○ 1 representative from Health Information Exchange		
Maryland	Quasi Governmental	*Exchange of Trustees*	9	• Secretary of Health and Mental Hygiene • Insurance Commissioner • Executive Director of Maryland Health Care Commission • Members appointed by Governor: ○ 3 representing interests of employers and individual ○ 3 with knowledge and experience in specific areas	• Members serve 4 year terms • No member can serve more than 2 consecutive terms • Members must not be affiliated with insurance carrier, production, third party administrator, or associations of these, or doing any other business with the exchange	• May appoint advisory committees • May contract with Maryland Medical Assistance Program, Dept of Human Resources, Insurance producers, third party administrators, or others not affiliated with carriers
Massachusetts	Quasi Governmental	*The Connector Authority*	11	• Secretary for Administration and Finance • Director of Medicaid • Commissioner of Insurance • Executive Director of the Group Insurance Commission • 4 appointed by Governor with the following affiliation or expertise:	• Cannot be employee of an insurance carrier	

				○ Actuary ○ Health economist ○ Small business ○ Underwriter • 3 appointed by Attorney General: • Employee health benefit plan specialist • Health consumer organization • Organized labor representative		
Nevada	Independent State Agency	*Silver State Exchange Board*	10	• Director of Department of Health and Human Services • Director of Department of Business and Industry • Director of Department of Administration • Five voting members appointed by the Governor • One voting member appointed by the Senate Majority Leader • One voting member appointed by the Speaker of Assembly	• Voting members may not be elected officials, state employees, or affiliated with a health insurer	
Oregon	Quasi Governmental Agency	*Health Insurance Exchange Board of Directors*	9	• Director of Oregon Health Authority • Director of Department of Consumer and Business Services • 7 appointed by Governor, including at least ○ 2 individual or small business Exchange consumers	• No more than 2 can be affiliated with insurer, third party administrator, producer, provider, facility, clinic, or trade association for these parties • Members must declare conflict of interest and abstain from voting	

Rhode Island	Independent State Agency	*Executive Board*	13	• Director of Department of Administration • Health Insurance Commissioner • Secretary of the Executive Office of Health and Human Services • Director of the Department of Health • 9 appointed by Governor, including: ○ 2 representing consumer organizations ○ 2 representing small businesses	• Cannot be employed by, consultant to, member of board of directors, or otherwise affiliated with an insurer, agent, broker, provider, facility or clinic • Cannot be provider unless no compensation is received for services and no ownership interest in a health care practice	
Utah	Existing State Agency	*Utah Health Exchange*	Up to 9	• Insurance Commissioner • 6 to 8 appointed by Governor, including: • 3 to 5 with actuarial expertise representing carriers, employers and employees, Office of Consumer Health Services, and Public Employees Health Benefit Program		
Vermont	Existing State Agency	*Health Reform Board*	5	• Chair named by governor, full time state employee • 4 part time state employees appointed by governor with advice/consent of senate ○ 1 expert in health policy/financing ○ 1 practicing physician ○ 1 rep having experience in or representing hospitals ○ 1 rep of consumers		Consumer and Healthcare Professional advisory board was created to advise Commissioner of Vermont health access on policy development and healthcare administration

Washington	Quasi Governmental	*Health Insurance Exchange Board*	11	• Commissioner of Insurance
				• Administrator of Health Care Authority
				• 9 appointed by Governor, including
				  • 4 selected from House and Senate nominees (employee benefit specialist, health economist or actuary, consumer advocate, small business owner)
				  • 4 with other specified expertise
					• Cannot have a financial interest in board decisions or represent an entity with a financial interest	

West Virginia	Existing State Agency	***Exchange Board***	10	• Board Chair: Insurance Commissioner (ex. Officio)
				• Director of WV Medicaid Office
				• Director of WV Children Health Insurance Program
				• Chair of WV Health Care Authority
				• 4 members appointed by Governor:
				  ○ 1 representing interest of individual consumer,
				  ○ 1 of small employer,
				  ○ 1 of organized labor, and
				  ○ 1 of insurance producers or navigators
				• 1 member representing interest of payers, selected by advisory group of 10 major carriers
				• 1 member representing interest of providers, selected by advisory group of 8 provider associations
					• Individual consumer serve term of 1 year
					• Small employer consumer serves terms of 2 years
					• Organized labor rep serves terms of 3 years
					• Insurance producer serves terms of 4 years
					• All other members serve terms of 4 years, with eligibility to be reappointed.
						Board may establish ad hoc or standing advisory committees

6.2. Additional Peer State Planning Efforts

The following analysis is of states indentified by Wyoming officials and PCG staff members as being of particular interest to Wyoming. For this reason, a more in-depth analysis was performed.

Colorado

On June 29, 2011, the Governor announced his appointments to the Health Benefit Exchange Board via Executive Order 2011-122. Exchange legislation included the provision that their Exchange will follow a clearinghouse purchasing model, similar to Utah.

Colorado has convened multiple workgroups and continues to hold advisory board meetings. On August 22, 2011, the Board discussed strategic decisions such as options for the Exchange business model, operational plan, systems alignment, SHOP services, and SHOP functionality. The board recommended that the Exchange have one administrative structure with two business lines: one for the small business market, one for the individual market. A motion was made and approved to form a subcommittee to review federal rules and regulations and develop a memo for the board to review.

In addition, the Colorado Department of Health Care Policy and Financing along with the Colorado Coalition for the Medically Underserved, the Colorado Consumer Health Initiative and the Health Reform Implementation Board are collaboratively hosting a series of community forums to discuss the health insurance exchange options for the state, and seek and collect input from stakeholders and consumers.

Idaho

Idaho's Department of Insurance and Department of Health and Welfare has established a partnership in generating a proposed Health Insurance Exchange for Idaho. The Departments have elicited broad and diverse public stakeholder involvement in the development of the proposed exchange. A total of eight workgroups have convened to discuss specific aspects of the Exchange. The first round of stakeholder meetings has concluded, and there are a total of six additional public stakeholder meetings scheduled.

Planning for Idaho's exchange is in progress and focused on stakeholder input, background research, legislative, program integration with Medicaid and CHIP, IT Systems, Project plan. Idaho has not proposed any legislation regarding the establishment of a Health Benefit Exchange; however the state is looking into a state controlled exchange.

Idaho plans to apply for Level 1 funding on September 30, 2011.

New Mexico

During the Legislative Session, a number of Health Care Reform related bills passed. However, Governor Martinez vetoed SB 38/370, which would have established a health insurance exchange for New Mexico. The Governor noted in Senate Executive Message No. 53 that she is in "general in support of the creation of a framework to establish a state insurance Exchange," but did not support this particular legislation. Bills that were passed include:

- SJM 1: Health Care Reform Work-group. Continuation of health care reform work group to assist state in preparing for and implementing ACA.
- SJM 14: Health Care Work Force Data Collection.
- SB 89: Allows for creation of health insurance purchasing cooperatives among employer.

New Mexico has had ongoing stakeholder consultation with consumers, providers, insurers, Medicaid, IT officials, and Native Americans. Consumer and insurer stakeholder meetings are held monthly. Informed by stakeholder discussions, the Office of Health Care Reform's (OHCR) second quarter report included a recommendation to establish a quasi-governmental agency for a single state Exchange.

Additionally, the Department of Health (DOH) and the Department of Workforce Solutions (DWS) is collaborating to collect and analyze workforce data. DWS recently received a planning grant to pursue the collection effort, and DOH is working to create a programmatic structure and technical design for processing the data.

The IT gap analysis has been executed, and will be completed in October. OHCR also received a Technical Assistance Grant from the Robert Wood Johnson Foundation. The grant allows New Mexico to collaborate with experts in various Exchange and healthcare related fields to assist the state in moving forward on health care reform.

Montana

Montana established an Exchange Interagency Workgroup and Exchange Stakeholder Involvement council in January 2011 and October 2010, respectively, to study the feasibility of implementing an Exchange in Montana and discuss the alternatives that are available to the state. The state has also completed an IT systems assessment and insurance market analysis to inform these discussions.

Montana introduced legislation twice last spring to establish an Exchange, one sponsored by Democratic members of Congress, the other by Republican; however, neither bill passed. During each legislative

debate, members of the business community, consumer groups, and insurers showed their support for the establishment of an Exchange, citing strong apprehension over potential federal control of their insurance marketplace. The Commissioner of Securities and Insurance has supported the creation of a "Made-in-Montana Health Insurance Exchange," noting that even if legislation does not pass to establish a state-run Exchange, Montana will still seek to participate in the planning of a federal-state partnership to operate an Exchange.

Nebraska

Nebraska's Exchange planning activities have focused on three broad areas: background research, IT assessments and planning, and stakeholder engagement, including several stakeholder meetings and surveys. The state's current debate revolves around the governance model that the state may choose to adopt if it decides to operate an Exchange. State officials are hesitant to make a decision regarding governance until further federal guidance becomes available. However, in response to Exchange planning debates in the state, a large group of businesses, health providers, associations, insurance carriers, and individuals has formed the Nebraska Health Alliance, a non-profit advocacy group in support of a state-run Exchange. The Alliance asserts that, if the Exchange is regulated by Nebraska, it will "empower consumers to determine which health plans suit them [and] meet Nebraska's unique needs."

Nevada

During the last year, Nevada has taken significant steps in planning for their Exchange, including the completion of an initial market analysis, IT gap analysis, health benefits assessment, and several rounds of stakeholder meetings.

Nevada applied for Level One funding in June of 2011, and was awarded $4,045,076. Nevada plans to use this funding to support the development of a new rules-based eligibility engine that will serve Medicaid, the Exchange, and CHIP, develop an operations plan, create a financial management and sustainability model, and prepare statutory and regulatory changes for the commercial insurance market.

North Dakota

North Dakota has enacted legislation stating its intent to establish a state operated Exchange (HB1126). The North Dakota Insurance Department recently held a forum to gather public input on the creation of the state's Exchange. The Health Care Reform Review Committee also held meetings on June 14, 2011, and August 4, 2011. In these meetings, they discussed further details of the Exchange governance

structure. Committee members recommended that the Exchange be housed within a new state agency and governed by a board of directors. Other recommendations included the implementation of an advisory committee made up of stakeholders and a standing committee. North Dakota's Health Care Reform Review Committee will be preparing a measure for possible introduction of Exchange establishment legislation during the legislative session in November.

South Dakota

In April of 2011, Governor Daugaard formed the South Dakota Health Insurance Exchange Task Force, which has several subgroups focusing on areas such as operations and financing, outreach and communication, and insurance plan and market organization. In August, a subcommittee of the task force recommended that the Exchange should not merge the individual and small group markets, and a single Exchange should facilitate enrollment for both the individual and small group market. Preliminary cost estimates were also presented.

In addition to the Task Force, the state has also dedicated staff members and hired contractors to accomplish the goals of the planning process. With respect to governance, stakeholder groups will review governance models and provide options to the Governor; however, enabling legislation will be required for the establishment of an Exchange. South Dakota has not yet proposed any legislation regarding the establishment of a Health Benefit Exchange.

Tennessee

While Tennessee has not yet proposed legislation for the establishment of an Exchange, the Department of Finance and Administration is actively studying the feasibility of Exchange implementation on behalf of the Governor's office. To this end, the state has completed an IT gap analysis and market study, and is planning a series of public forums statewide to solicit stakeholder feedback on Exchange implementation options. In considering Exchange implementation, the state has taken the approach that all services and functions will be contracted to third parties such that no existing state resources will be dually burdened by introducing Exchange processes. The state intends to submit an application for Level One funding for September 30, 2011.

Utah

Utah began planning a defined contribution health insurance exchange for their state in 2005, focusing on three main goals:

1. Provide ways to stabilize costs for the employer in order to make health insurance premium costs more predictable

2. Allow employers to continue to enjoy the same tax treatment with deductibility of employer premium payments and the ability for employees to pay for their portion of the premium with pre-tax dollars

3. Focus on giving the consumer more control over their own health care decisions

The Exchange, supported by the passage of critical legislation in 2008 and 2009, currently covers 4,200 lives including 165 employer groups. As of this writing, the Utah Exchange is, by their own acknowledgement, not compliant with all of the requirements of the ACA. Patty Connor, the Director of the Utah Health Exchange commented that, "If the law goes into effect and all the court cases have been heard, and we're required to put those actions in place, we will certainly do that."

Utah has identified certain areas as "critical learning" lessons from their defined contribution launch, as follows:

- Premium Parity – Adverse selection could not be avoided unless the premiums for like products are priced the same both inside and outside the exchange. This principle should also apply to restrictions on renewal rates.

- Broker Engagement –Brokers provided value from the outset of Exchange planning to help distribute the products, publicize the advantages of the Exchange, help with communications with customers (employers and employees), give important input to the technology partners and find errors in the system.

- Insurer Engagement – Utah found it valuable to give insurers a significant degree of latitude in bringing their expertise to assist in the design and development of the system.

- Leveraging Private Solutions –Utah worked with private vendors to help develop their Exchange, especially those with core competencies closely matched to their part of the project. Instead of selecting one vendor to provide all their needs, Utah opted for more collaborative approach with a number of firms working together toward a common goal.

- Employer Support – Employers electing to participate in the Utah Exchange wanted assurance that the premiums available through the exchange would be and stay competitive when compared to those outside the Exchange. The requirement that pricing be the same inside and outside the

Exchange is regarded as a critical decision and helped put an end to the severe adverse selection they first experienced.